BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: WASHINGTON BRYAN, M.D. Physician's and Surgeon's Certificate No. A 61799 Respondent.	File No. 17-2005-165967

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby accepted and adopted as the Decision and Order by the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 4, 2011.

DATED January 5, 2011

MEDICAL BOARD OF CALIFORNIA

Shelton Duruisseau

Shelton Duruisseau, Ph.D.
Panel A

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General
E. A. JONES III
Deputy Attorney General
State Bar No. 71375
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2543
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **WASHINGTON BRYAN, M.D.,** Respondent.	Case No. 17-2005-165967 OAH No. 2008100490 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Second Amended Accusation and Medical Board investigation case numbers 17-2005-165967, 17-2006-177661, 17-2007- 183351, 17-2008-195534, 17-2008-195536, and 17-2007-185414.

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by E. A. Jones III, Deputy Attorney General.

2. Respondent Washington Bryan, M.D. (Respondent) is represented in this proceeding

by attorney Peter Osinoff, whose address is 3699 Wilshire Blvd., 10th Floor, Los Angeles, California 90010-2719.

3. On or about March 14, 1997, the Medical Board of California issued Physician's and Surgeon's Certificate No. A61799 to Washington Bryan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 17-2005-165967 and will expire on March 31, 2011, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 17-2005-165967 was filed before the Medical Board of California, Department of Consumer Affairs (Board), and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on August 3, 2010. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Second Amended Accusation No. 17-2005-165967 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 17-2005-165967. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Second Amended Accusation No. 17-2005-165967, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Second Amended Accusation without the expense and uncertainty of further proceedings, Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Second Amended Accusation No. 17-2005-165967 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Second Amended Accusation No. 17-2005-165967 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that facsimile copies of this Stipulated Settlement

and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A61799 issued to Washington Bryan, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. PRESCRIBING PRACTICES COURSE Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole

discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. ETHICS COURSE Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in ethics, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MONITORING - PRACTICE/BILLING Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice and billing monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including, but not limited to, any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision,

Second Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Second Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Second Amended Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit for approval by the Board or its designee a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice and billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours, and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and billing, and whether Respondent is practicing medicine safely and billing appropriately.

It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Board or designee.

In lieu of a monitor, Respondent may participate in a professional enhancement program

equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

5. NOTIFICATION Prior to engaging in the practice of medicine, the Respondent shall provide a true copy of the Decision(s) and Second Amended Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, Respondent is prohibited from supervising physician assistants.

7. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

8. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. PROBATION UNIT COMPLIANCE Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business

and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

Respondent shall immediately inform the Board, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

11. RESIDING OR PRACTICING OUT-OF-STATE In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California total two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in

another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

12. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

13. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have

continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board. The costs associated with probation monitoring may be adjusted on an annual basis by the Board. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter Osinoff. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/24/2010 W Bryan MD

WASHINGTON BRYAN, M.D.
Respondent

I have read and fully discussed with Respondent Washington Bryan, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/3/10

BONNE, BRIDGES, MUELLER, O'KEEFE AND NICHOLS
A PROFESSIONAL CORPORATION
By PETER OSINOFF
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: _____

Respectfully Submitted,

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General

E. A. JONES III
Deputy Attorney General
Attorneys for Complainant

LA2008502048
50719279.doc

I have read and fully discussed with Respondent Washington Bryan, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

BONNE, BRIDGES, MUELLER, O'KEEFE AND NICHOLS
A PROFESSIONAL CORPORATION
By PETER OSINOFF
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 9/7/10

Respectfully Submitted,

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General

E. A. JONES III
Deputy Attorney General
Attorneys for Complainant

LA2008502048
50719279.doc

Exhibit A

Second Amended Accusation No. 17-2005-165967

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General
E. A. JONES III
Deputy Attorney General
State Bar No. 71375
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2543
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **WASHINGTON BRYAN, M.D.** **11600 WILSHIRE BLVD., SUITE 205** **LOS ANGELES, CA 90025** **PHYSICIAN'S AND SURGEON'S CERTIFICATE NO. A61799** Respondent.	Case No. 17-2005-165967 OAH No. 2008100490 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Second Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On or about March 14, 1997, the Medical Board of California issued Physician's and Surgeon's Certificate Number A61799 to Washington Bryan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2011, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless

otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division,[1] may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the division and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical

[1] Pursuant to Business and Professions Code section 2002, "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

8. Section 725 of the Code stated at all times relevant to the charges in this matter:[2]

---

[2] As amended effective January 1, 2007, section 725 states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor,

(continued...)

"Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist. However, pursuant to Section 2241.5, no physician and surgeon in compliance with the California Intractable Pain Treatment Act shall be subject to disciplinary action for lawfully prescribing or administering controlled substances in the course of treatment of a person for intractable pain."

9. Health and Safety Code section 11164 provides in part as follows:

"Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

"(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

"(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number...."

MEDICATIONS

10. Oxycodone is a dangerous drug as defined in section 4022 of the Business and Professions Code and is a schedule II controlled substance as defined in Health and Safety Code section 11055. Oxycodone is an analgesic indicated for relief of moderate to moderately severe

---

optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

pain and is marketed under the trade names OxyContin, Roxycodone and Percocet.

11. Methadone is a dangerous drug as defined in section 4022 of the Business and Professions Code and is a schedule II controlled substance as defined in Health and Safety Code section 11055. Methadone is synthetic opioid uses as an analgesic and antitussive.

12. Fentanyl citrate is a dangerous drug as defined in section 4022 of the Business and Professions Code and is a schedule II controlled substance as defined in Health and Safety Code section 11055 which is marketed under the trade name Actiq.

13. Diazepam is a dangerous drug as defined in section 4022 of the Business and Professions Code and is a schedule IV controlled substance as defined in Health and Safety Code section 11057. Diazepam is a benzodiazepine tranquilizer indicated for relief of anxiety, tension fatigue, agitation, muscle spasm and seizure, irritable bowel syndrome and panic attacks which is marketed under the trade name Valium.

14. Alprazolam is a dangerous drug as defined in section 4022 of the Business and Professions Code and is a schedule IV controlled substance as defined in Health and Safety Code section 11057. Alprazolam is a short-acting drug of the benzodiazepine class used to treat moderate to severe anxiety disorders, panic attacks, and as an adjunctive treatment for anxiety associated with clinical depression which is marketed under the trade name Xanax.

15. Dilaudid is a brand name for hydromorphone hydrochloride, an opioid analgesic, and it is a dangerous drug within the meaning of Business and Professions Code section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(k)

16. Doxepin is a dangerous drug as defined in section 4022 of the Business and Professions Code and is a schedule IV controlled substance as defined in Health and Safety Code section 11057. It is a psychotropic agent with antidepressant and anxiolytic properties. It also has sedative and anticholinergic effects, and, in the higher dosage range, it produces peripheral adrenergic blocking effects.

17. Vicodin is a brand name for hydrocodone bitartrate and acetaminophen, an opioid analgesic and antitussive, and it is a dangerous drug within the meaning of Business and

Professions Code section 4022 and a Schedule III controlled substance under Health and Safety Code section 11056, subdivision (e)(4).

18. Phenergan with codeine is a brand name for promethazine with codeine and it is a dangerous drug within the meaning of Business and Professions Code section 4022 and a Schedule V controlled substance under Health and Safety Code section 11058, subdivision (c)(1).

19. Cymbalta is a brand name for duloxetine, an antidepressant in a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs), and it is a dangerous drug within the meaning of Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in the care and treatment of patient J.Y. The circumstances are as follows:

Factual Allegations re Patient J.Y.

21. On or about May 22, 2002, patient J.Y. first presented to Respondent. Respondent did not maintain any records of this visit. No history and physical examination was performed and/or documented during this visit. There was no documentation that Respondent obtained information from any prior treating physicians.

22. On or about May 24, 2002, patient J.Y. presented to Respondent and signed a narcotic pain management agreement and consent. No initial history and physical examination was performed and/or documented during this visit or subsequently. There was no documentation that Respondent obtained information from any prior treating physicians. Respondent was not aware that the patient was receiving pain management medications from other physicians, even though his pain management contract with the patient required her to receive such medications only from him.

23. On or about May 24, 2002, Respondent wrote a prescriptions for patient J.Y. for 90 tablets of methadone 5 mg for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the University of California, Irvine (UCI) Medical

Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

24. On or about June 12, 2002, patient J.Y. was seen by Respondent. Respondent prescribed 10 Fentanyl 150 mg patches. Respondent used a prescription form that did not have his provider address, but set forth the address of the University of California, Irvine (UCI) Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

25. From on or about June 12, 2002, through March 17, 2003, Respondent used a prescription form for prescribing controlled substances that did not have his provider address and telephone number, but set forth the address of the University of California, Irvine (UCI) Medical Center Department of Anesthesiology with which he was no longer affiliated.

26. On or about June 19, 2002, Respondent prescribed patient J.Y. 15 Fentanyl 75 mg patches for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

27. On or about June 21, 2002, Respondent prescribed patient J.Y. 180 Percocet 10/325 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

28. On or about July 3, 2002, Respondent prescribed patient J.Y. 100 Dilaudid 4 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

29. On or about July 30, 2002, Respondent prescribed patient J.Y. 120 OxyContin 20 mg tablets for pain and 100 tablets of Percocet 10/325 mg for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did chart a progress notes regarding the visit.

30. On or about August 26, 2002, Respondent prescribed patient J.Y. 58 OxyContin 40 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

31. On or about September 3, 2002, Respondent prescribed patient J.Y. 10 Fentanyl 75 mg patches for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

32. On or about September 9, 2002, patient J.Y. was seen by Respondent with a chief complaint regarding the side-effects of pain medications. The patient reported taking Xanax, Enalapril, Corega, Effexor, Buspiroen, Neurontin, Fentanyl, Zomig and Dilaudid. The assessment was bilateral thoracic outlet syndrome and the plan was to discontinue Neurontin secondary to side effects, discontinue Effexor (after conferring with Victor Amira, M.D. by phone), Xanax 1 mg, Fentanyl 75 mg patches and follow-up in 1 week. On or about September 9, 2002, Respondent prescribed patient J.Y. 20 Fentanyl 75 mg patches for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated.

33. On or about September 16, 2002, Respondent prescribed patient J.Y. 100 OxyContin 10 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

34. On or about September 23, 2002, Respondent prescribed patient J.Y. 41 OxyContin 20 mg tablets for pain and noted the patient was to wean as directed. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

///

35. On or about October 7, 2002, Respondent approved three refills for patient J.Y. of 60 Diazepam 10 mg tablets. Respondent did not chart any progress notes for the office visit.

36. On or about October 22, 2002, Respondent prescribed patient J.Y. 90 OxyContin 80 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

37. On or about October 28, 2002, Respondent prescribed patient J.Y. 250 Dilaudid 4 mg tablets for pain with two prescriptions. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

38. On or about November 11, 2002, Respondent prescribed patient J.Y. 100 Dilaudid 4 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

39. On or about November 11, 2002, Respondent prescribed patient J.Y. 100 Dilaudid 4 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent also prescribed 100 tablets of OxyContin 80 mg for pain on this date on a UCI prescription form that did not have his provider address. Respondent did not chart any progress notes for the office visit.

40. On or about November 26, 2002, Respondent prescribed patient J.Y. 100 OxyContin 80 mg for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent also prescribed 24 Fentanyl 200 mcg lozenges on this date on a UCI prescription form that did not have his provider address. Respondent did not chart any progress notes for the office visit.

///

41. On or about December 10, 2002, Respondent prescribed patient J.Y. 2 boxes (24) 400 mcg Fentanyl lozenges for breakthrough pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent also prescribed 100 tablets of OxyContin 80 mg tablets on this date on a UCI prescription form that did not have his provider address. Respondent's chart contains a blank billing form for this date. Respondent did not chart any progress notes for the office visit.

42. On or about December 31, 2002, Respondent prescribed patient J.Y. 2 boxes (24) 400 mcg Fentanyl lozenges for breakthrough pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent also prescribed 100 tablets of OxyContin 80 mg tablets on this date on a UCI prescription form that did not have his provider address. Respondent did not chart any progress notes for the office visit.

43. On or about January 14, 2003, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent also prescribed 96 lozenges of Actiq 400 mcg for breakthrough pain on this date on a UCI prescription form that did not have his provider address. Respondent's chart contains a blank billing form for this date. Respondent did not chart any progress notes for the office visit.

44. On or about January 27, 2003, Respondent prescribed patient J.Y. 48 Actiq 400 mcg lozenges for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent also prescribed another 48 Actiq 800 mcg lozenges for pain on this date on a UCI prescription form that did not have his provider address. Respondent's chart contains a billing form for this date noting two epidural injections. Respondent did not chart any progress notes for the office visit. Respondent did not chart a procedure note for the injections.

45. On or about January 30, 2003, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

46. On or about February 3, 2003, Respondent approved five refills for patient J.Y. of 60 Alprazolam 1 mg tablets. Respondent did not chart any progress notes for the office visit.

47. On or about February 4, 2003, Respondent prescribed patient J.Y. 24 "fentanyl lozenges (Actiq) 400 mcg" for pain. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

48. On or about February 13, 2003, Respondent annotated a billing form for a comprehensive, high complexity office visit with patient J.Y. On this date Respondent prescribed 3 boxes (24 per box) of Actiq 800 mcg for pain. He also prescribed on this date 2 boxes (24 per box) of Actiq 1200 mcg lozenges for breakthrough pain as well as 100 OxyContin 80 mg. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

49. On or about February 21, 2003, Respondent prescribed 100 OxyContin 80 mg. Respondent used a prescription form that did not have his provider address, but set forth the address of the UCI Medical Center Department of Anesthesiology with which he was no longer affiliated. Respondent did not chart any progress notes for the office visit.

50. On or about March 1, 2003, Respondent prescribed 3 boxes (24 per box) of Fentanyl 800 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

51. On or about March 5, 2003, Respondent annotated a billing form for a problem focused office visit with patient J.Y. On this date Respondent prescribed 100 OxyContin 80 mg tablets. He also prescribed 100 Fentanyl 800 mcg lozenges for pain on this date along with a

further prescription for 96 Fentanyl 800 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

52. On or about March 7, 2003, Respondent prescribed 72 Actiq 800 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

53. On or about March 10, 2003, Respondent annotated a billing form for a comprehensive, high complexity office visit with patient J.Y. Respondent prescribed 100 morphine sulfate IR 30 mg tablets for pain, 100 tablets of OxyContin 80 mg and 24 lozenges of Fentanyl 800 mcg for pain. Respondent did not chart any progress notes for the office visit.

54. On or about March 17, 2003, Respondent annotated a billing form for a problem focused office visit with patient J.Y. Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain. Respondent noted in a progress note that patient J.Y. was being seen by him for ongoing management of chronic pain. There was a note about "postoperative" pain but no notation regarding any recent surgery. He also noted that she was seeing a rheumatologist and a primary care physician. He did not chart any communication with them.

55. On or about March 25, 2003, Respondent annotated a billing form for a problem focused office visit with patient J.Y. Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain as well as two prescriptions for Fentanyl 800 mcg, one for 24 and one for 72 lozenges. Respondent did not chart any progress notes for the office visit.

56. On or about April 1, 2003, Respondent annotated a billing form for a problem focused office visit with patient J.Y. and for two injections (to the neck and face). Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain as well as 72 Fentanyl 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit. Respondent did not chart a procedure note for the injections.

57. On or about April 3, 2003, Respondent annotated a billing form for an interim office visit with patient J.Y. Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain as well as 96 Fentanyl 400 mcg lozenges for pain. Respondent charted a SOAP note for this visit that patient J.Y. was being seen by him for ongoing management of intractable pain.

///

58. On or about April 15, 2003, Respondent annotated a billing form for a problem focused office visit with patient J.Y. On this date, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain as well as 72 Fentanyl 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

59. On or about April 22, 2003, Respondent annotated a billing form for a problem focused office visit with patient J.Y. On this date, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain as well as 96 Actiq 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

60. On or about April 22, 2003, Respondent annotated a billing form for a comprehensive, high complex office visit with patient J.Y. On this date, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets for pain as well as 96 Actiq 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

61. On or about April 29, 2003, Respondent annotated a billing form for a comprehensive, high complex office visit with patient J.Y. On this date, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets as well as 96 Actiq 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

62. On or about May 6, 2003, Respondent annotated a billing form for a comprehensive, high complex office visit with patient J.Y. On or about May 6, 2003, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets as well as 96 Actiq 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

63. On or about May 12, 2003, Respondent annotated a billing form for an expanded problem focused office visit with patient J.Y. On this date, Respondent prescribed patient J.Y. 100 tablets of OxyContin 80 mg tablets as well as 96 Actiq 400 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

64. From on or about May 19, 2003, through in or around October 2005, Respondent regularly wrote two prescriptions for patient J.Y. each for 100 tablets of OxyContin 80 mg tablets for pain, neck pain or thoracic outlet syndrome as well as two prescriptions for 96 Actiq 1600 mcg lozenges for pain, breakthrough pain or thoracic outlet syndrome. Respondent did not chart

any progress notes for the office visit.

65. On or about January 21, 2004, Respondent authorized a new prescription for 60 tablets of Diazepam 5 mg for patient J.Y.

66. On or about June 22, 2004, Respondent annotated a billing form for a comprehensive and high complex office visit for patient J.Y. Respondent wrote seven prescriptions for 100 tablets of OxyContin 80 mg for chronic pain. Respondent wrote thirteen prescriptions for 90 Actiq 1600 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

67. On or about August 5, 2004, Respondent next saw the patient and annotated a billing form for a comprehensive and high complex office visit for patient J.Y. Respondent wrote one prescription for 100 tablets of OxyContin 80 mg for chronic neck pain. He also wrote two prescriptions for 90 Actiq 1600 mcg lozenges for pain. Respondent did not chart any progress notes for the office visit.

68. On or about April 8, 2005, Respondent annotated a billing form for two surgical procedures during an office visit for patient J.Y. Respondent did not make a procedure note in the chart. Respondent wrote one prescription for 100 tablets of OxyContin 80 mg for "brachial neuritis." He also wrote four prescriptions for 90 Actiq 1600 mcg for the same condition. Respondent did not chart any progress notes for the office visit. Respondent next saw the patient on April 22, 2005, and wrote the same number and type of prescriptions once again. He also wrote prescriptions for 90 Diazepam 10 mg for muscle spasm/anxiety, 180 Alprazolam 2 mg with 4 refills, and 270 Diazepam 10 mg for anxiety/muscle spasms with four refills. Respondent did not chart any progress notes for the office visit.

69. In or around June 2005, Respondent replaced OxyContin with prescriptions for 100 Methadone 40 mg for chronic pain, thoracic outlet syndrome. For example, on or about July 14, 2005, Respondent annotated a billing form for an office visit and wrote four prescriptions for 100 Methadone 40 mg for chronic pain, thoracic outlet syndrome and five prescriptions for 100 Actiq 1600 mcg lozenges. Respondent next saw the patient two weeks later. Respondent did not chart any progress notes for the office visit. Respondent continued prescribing Methadone through

March 2007.

70. On or about October 4, 2006, Respondent authorized a prescription for 30 tablets of Doxepin 75 mg with eleven refills for patient J.Y.

71. On or about December 12, 2006, patient J.Y. executed a "Consent Form for Chronic Narcotic Pain Medication" and a "Consent for Opioid Therapy." The patient also filled out a 14 page "Pain Clinic Comprehensive Pain Management Questionnaire."

72. During the course of treatment of patient J.Y. from 2004 through 2007, Respondent failed to document any reassessment of the patient's medication regimen. Respondent also failed to document any consultations sought or obtained from any psychiatrists, psychologists and/or addictionologists. Respondent failed to document physical therapy provided or urine screens and CURES[3] reports ordered during this period.

Allegations of Gross Negligence re Patient J.Y.

73. On or about May 22, 2002, and thereafter during the course of his treatment of patient J.Y., Respondent was grossly negligent when he failed to perform and/or document an initial history and physical examination of patient J.Y.

74. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was grossly negligent when he failed to perform and/or document periodic patient evaluations.

75. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was grossly negligent when he failed to document procedure notes for injections or other procedures.

76. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was grossly negligent when he failed to refer the patient for consultations with psychiatrists, psychologists and/or addictionologists.

///

[3] The CURES report is a "Controlled Substance Utilization Review and Evaluation System" report regarding a patient's prescription history generated by the California Department of Justice, Bureau of Narcotic Enforcement. It is available to a physician upon request and shows the patient's narcotic prescription history with all physicians prescribing to the patient.

77. On or about May 22, 2002, and thereafter through in or around March 2007, including on or about October 7, 2002, February 3, 2003, January 14, 2004, January 21, 2004, April 8, 2005, and October 4, 2006, during the course of his treatment of patient J.Y., Respondent was grossly negligent when he failed to document a medical indication for prescribing anxiolytics to patient J.Y.

78. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was grossly negligent when he failed to maintain adequate and accurate records of the medical services provided to patient J.Y.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

79. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent was engaged in repeated acts of negligence in the care and treatment of patient J.Y. The circumstances are as follows:

Factual Allegations Regarding Patient J.Y.

80. The facts and circumstances alleged in paragraphs 21 through 72 above are incorporated here as if fully set forth.

Allegations of Negligence Regarding Patient J.Y.

81. On or about May 22, 2002, and thereafter during the course of his treatment of patient J.Y., Respondent was negligent when he failed to perform and/or document an initial history and physical examination of patient J.Y.

82. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was negligent when he failed to perform and/or document periodic patient evaluations.

83. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was negligent when he failed to document procedure notes for injections or other procedures.

84. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was negligent when he failed to refer the

patient for consultations with psychiatrists, psychologists and/or addictionologists.

85. On or about May 22, 2002, and thereafter through in or around March 2007, including on or about October 7, 2002, February 3, 2003, January 14, 2004, January 21, 2004, April 8, 2005, and October 4, 2006, during the course of his treatment of patient J.Y., Respondent was negligent when he failed to document a medical indication for prescribing anxiolytics to patient J.Y.

86. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent was negligent when he failed to maintain adequate and accurate records of the medical services provided to patient J.Y.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

87. Respondent is subject to disciplinary action under section 725 of the Code in that Respondent clearly excessively, and repeatedly, prescribed medications to a patient. The circumstances are as follows:

88. On or about May 22, 2002, and thereafter through in or around March 2007, during the course of his treatment of patient J.Y., Respondent excessively prescribed narcotic medications to patient J.Y.

FOURTH CAUSE FOR DISCIPLINE

(Record Keeping)

89. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records of the medical services he provided to a patient. The circumstances are as follows:

90. The facts and circumstances alleged in paragraphs 21 through 72 above are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Violation of Drug Laws)

91. Respondent is subject to disciplinary action under section 2238 of the Code in that Respondent engaged in unprofessional conduct when he violated Health and Safety Code section

11164, subdivision (a)(1). The circumstances are as follows:

92. From on or about June 12, 2002, through March 17, 2003, Respondent used prescription forms from the UCI, Medical Center, Department of Anesthesiology when he was no longer affiliated with that institution and had opened his own practice on West Los Angeles, in violation of Health and Safety Code section 11164, subdivision (a)(1), which requires the prescriber's address and telephone number on the prescription.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

93. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that respondent was grossly negligent in the care and treatment of patients. The circumstances are as follows:

Factual Allegations re Patient P.D.

A. On or about September 20, 2004, patient P.D., a 60-year-old woman, presented to respondent complaining of neck, back and leg pain. A patient history form in the chart, presumably filled in by the patient, indicates the patient had hypertension, coronary artery disease and epilepsy. There is a notation, presumably by respondent, indicating a history of "triple bypass." The patient indicated she smoked two packs of cigarettes daily. A handwritten impression at the end of the questionnaire indicated diagnoses of lumbar stenosis, lumbar radiculopathy, and cervical facet disease with a plan to prescribe OxyContin and Dilaudid. There is no evidence of any other history taken by respondent; there is no documentation of a physical examination by respondent apart from blood pressure and pulse notations. An informed consent for chronic opioid analgesic therapy signed by the patient and respondent on this date is in the chart. There is no documentation of a substance abuse history. There is no documentation or discussion of a differential diagnosis. No treatment plan or treatment goals are documented.

B. Respondent's chart for patient P.D. contains multiple preprinted encounter forms reflecting dates of service and charges from September 20, 2004, through October 31, 2006; some also contain blood pressure and pulse. One of the encounter forms dated

February 14, 2005, indicates that injections were performed in the patient's mid-back or thoracic region for treatment of postherpetic neuralgia using fluoroscopy. There is no procedure note documented for the injections. There is no documentation of diagnostic evaluations with laboratory testing or radiography. Respondent's chart for patient P.D. does not contain any progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment or whether the patient was experiencing any side effects.

C. Respondent's chart for patient P.D. contains twenty-one (21) prescriptions signed by respondent for OxyContin 80 mg, quantity 90 as well as 21 prescriptions signed by respondent for Dilaudid 4 mg, with quantities ranging from 100 to 240, but usually 150. Not contained in the chart but reflected in pharmacy records from St. John's Medical Pharmacy are prescriptions from respondent for patient P. D. for hydrocodone/acetaminophen on February 14, 2005, and March 9, 2005, and promethazine with codeine cough syrup on November 8, 2006. Similarly absent from the medical record for the patient are 13 prescriptions from respondent for hydrocodone/acetaminophen 7.7/750, quantity 120 with variable refills between May 5, 2005, and September 21, 2006, from Twenty Two Twenty Two Pharmacy. In addition, from the same pharmacy, there were 13 prescriptions for Phenergan with codeine cough syrup, with variable refills; none of these are reflected in respondent's chart for patient P.D. There is no indication from the medical record that the patient had a respiratory ailment warranting the use of narcotic cough syrup. While there is a patient drug activity report from the Department of Justice indicating that the patient was obtaining narcotics from two other physicians during the period she was seen by respondent, contrary to the consent for chronic opioid analgesic therapy, there is no documentation that respondent discussed the patient with the two other physicians or discussed the issue with the patient.

Allegations of Gross Negligence re Patient P. D.

D. On or about September 20, 2004, and thereafter, respondent was grossly negligent in the care and treatment of patient P.D. when he failed to perform an appropriate

prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid and promethazine with codeine cough syrup.

E. Between on or about September 20, 2004, and October 31, 2006, respondent was grossly negligent in the care and treatment of patient P.D. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

F. Between on or about September 20, 2004, and October 31, 2006, respondent was grossly negligent in the care and treatment of patient P.D. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, (4) periodic reviews of pain management, (5) all prescription provided to the patient.

Factual Allegations re Patient P.E.

G. On or about May 4, 2005, patient P.E., a 51-year-old man, presented to respondent, per the patient questionnaire in the chart, complaining of severe arthritis and high blood pressure and indicating a desire for Vicodin, OxyContin, Dilaudid, water pills and potassium. The patient indicated his pain started 25 years earlier and was located "all over." The patient denied having diabetes and indicated that he had for three years used an non-narcotic anti-inflammatory drug and for two years Vicodin, both prescribed by a Dr. McIntosh. He rated his pain at 9.5/10. Patient P.E. reported some depressive symptoms (feeling sad or depressed, having poor appetite, trouble sleeping, having trouble with memory or concentration and thoughts of suicide in the prior year). He noted that he smoked one pack of cigarettes daily but did not drink, though he had a history of heavy drinking. There is no further development of a substance abuse history. Respondent or an assistant noted on the last page that the patient was having pain in "every joint" and noted

an impression of "Rheumatoid." Although blood pressure and pulse were noted, there was no other evidence of a physical examination. There was no complete description of the pain in regard to location, intensity and impact upon functioning. A two page consent form for chronic narcotic pain medication was signed by the patient and respondent this date. There were no notes detailing the patient's symptoms, examination findings, differential diagnosis, treatment plan or treatment goals. There was no documentation that respondent ever spoke to Dr. McIntosh or attempted to obtain his records to ensure that his treatment would not interfere with the treatment of Dr. McIntosh and to ensure that both physicians did not simultaneously prescribe controlled substances to the patient.

H. Respondent's medical chart for patient P.E., running from May 4, 2005, through November 17, 2006, contained mostly blank encounter forms. There are no progress notes detailing the patient's symptom, examination findings, adverse side effects, treatment goals or adherence to treatment.

I. Respondent's medical chart for patient P.E., running from May 4, 2005, through November 17, 2006, contains a number of prescriptions for OxyContin, Dilaudid, Vicodin (hydrocodone), Phenergan with codeine cough syrup, Enbrel, Viagra and Cymbalta. A pint of Phenergan with codeine cough syrup was prescribed on October 28, 2005; November 22, 2005 (with four refills); February 16, 2006 (with five refills); and August 16, 2006 (with four refills). The medical chart does contain two patient activity reports from the Department of Justice requested by respondent on October 28, 2005, and November 3, 2005. Both indicated no schedule II or III activity for the patient. Evidence outside the chart indicates that patient P.E. between October 20, 2006, and April 19, 2007, obtained opioid pain medicines from five different physicians and used four different pharmacies, suggesting a pattern of doctor shopping and implying possible drug addiction problems. There is no documentation that respondent requested the patient to provide a specimen for random urine drug screen to assess whether the patient might have been abusing illicit drugs, such as methamphetamine or cocaine. There is no documentation in respondent's medical record for patient P.E. of a respiratory ailment warranting the use of

narcotic cough syrup.

J. On or about October 13, 2006, respondent prescribed Cymbalta (with four refills) for the patient. Cymbalta is approved for diabetic peripheral neuropathy pain, fibromyalgia, major depressive disorder and generalized anxiety disorder. There is no documented work-up of the patient's depressive history. There is no subsequent documentation that respondent followed the patient while he was taking the Cymbalta in order to be able to address and side effects, such as suicidal ideation.

Allegations of Gross Negligence re Patient P. E.

K. On or about May 4, 2004, and thereafter, respondent was grossly negligent in the care and treatment of patient P.E. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid, Vicodin and Phenergan with codeine cough syrup.

L. Between on or about May 4, 2004, and November 17, 2006, respondent was grossly negligent in the care and treatment of patient P.E. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, his adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

M. Between on or about May 4, 2004, and November 17, 2006, respondent was grossly negligent in the care and treatment of patient P.E. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

N. On or about May 4, 2004, and thereafter, respondent was grossly negligent in the care and treatment of patient P.E. when he failed, prior to prescribing him controlled substances, to establish whether the patient was a drug addict by developing a complete

substance abuse history, requesting the patient to provide a specimen for random urine drug screening, performing an appropriate history and physical examination, obtaining the patient's prior medical records and speaking with and/or coordinating treatment with prior treating physicians.

O. On or about October 13, 2006, and thereafter, respondent was grossly negligent in the care and treatment of patient P.E. when he prescribed Cymbalta to patient P.E. without a prior examination and medical indication for the prescription and without proper follow- up with the patient.

P. On or about October 28, 2005, November 22, 2005, February 16, 2006, and August 16, 2006, respondent was grossly negligent in the care and treatment of patient P.E. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescription.

Factual Allegations re Patient W.G.

Q. On or about November 18, 2004, patient W.G., a 75-year-old woman, presented to respondent with complaints of "pain all over" her neck, back and legs. The chart contains a patient history questionnaire evidently filled out by a third person. It notes she had had four strokes, her pain is described as constant and severe with an intensity of 10/10, that she is not seeing any other physician, and that she was taking Dilaudid and OxyContin. A handwritten impression on the questionnaire notes "post stroke" and a plan to prescribe OxyContin and Dilaudid. The chart contains a consent form for chronic pain medications for a different patient. There is no documentation of history taken by respondent apart from the handwritten notation above. There is no documentation of a physical examination by respondent, including an absence of vital signs. There is no evidence in the chart that respondent conducted any diagnostic evaluation by way of lab tests or x-rays. There is no differential diagnosis. Hemiplegia is printed on the encounter forms and central pain is written on some of the opioid prescriptions. There is no documentation of a treatment plan or treatment goals. The patient died on June 10, 2006.

///

R. Respondent's chart for patient W.G. contains multiple preprinted encounter forms reflecting dates of service and charges but there is no history or physical examination recorded on these forms nor any progress notes relating to respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment and whether the patient was experiencing any adverse effects from respondent's treatment.

S. Between on or about November 18, 2004, and October 30, 2006, respondent's chart for patient W.G. contains multiple prescriptions by respondent, including 25 prescriptions for OxyContin 80 mg, number 90, and 25 prescriptions for Dilaudid 4 mg, with quantities ranging from 100 to 240. This represented a high dose opioid therapy for chronic pain. The chart contains two pharmacy refill request forms for Phenergan with codeine cough syrup and Vicodin extra strength (hydrocodone 75 mg/ acetaminophen 750 mg) signed by respondent on January 13, 2006, with five refills; and on May 25, 2006, with four refills. Pharmacy records from St John's Medical Pharmacy contained one prescription for patient W.G. for hydrocodone/acetaminophen 7.5/750, quantity 120, dated March 9, 2005; no record of this prescription was found in respondent's medical chart for the patient. In the records for Twenty Two Twenty Two Pharmacy there are 12 prescriptions from respondent for hydrocodone/acetaminophen 7.5/750, quantity 120, during the time frame from March 30, 2005, through March 1, 2006. During the same time frame, there are 11 prescriptions from respondent for Phenergan with codeine cough syrup. None of the hydrocodone/acetaminophen and Phenergan with codeine prescriptions from Twenty Two Twenty Two Pharmacy are in respondent's chart for the patient. There is no indication from respondent's medical record for patient W.G. that the patient has a respiratory ailment warranting the use of narcotic cough syrup. There is a November 10, 2005, patient activity report from the Department of Justice for patient W.G. in the chart; it reflects that the patient received narcotics from two other physicians while under respondent's care and obtained her medications from five different pharmacies. There is no documentation that respondent consulted with the two other physicians about the care and treatment of the patient or that he took any appropriate action after reviewing the report.

Allegations of Gross Negligence re Patient W.G.

T. On or about November 18, 2004, and thereafter, respondent was grossly negligent in the care and treatment of patient W.G. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid, Vicodin and Phenergan with codeine cough syrup.

U. Between on or about November 18, 2004, and June 10, 2006, respondent was grossly negligent in the care and treatment of patient W.G. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, his adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

V. Between on or about November 18, 2004, and June 10, 2006, respondent was grossly negligent in the care and treatment of patient W.G. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

W. Between on or about March 30, 2005, and March 1, 2006, respondent was grossly negligent in the care and treatment of patient W.G. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescriptions.

Factual Allegations re Patient A.H.

X. On or about May 10, 2005, patient A.H., a 53-year-old woman, presented to respondent. According to a patient history questionnaire, the patient described having a sudden onset of pain in her right foot and knee starting May 5, 2005. The pain was described by her as constant and with an intensity of 8/10. The patient first noted that she had not tried any treatments other than ice but later noted medicine she was taking as

"oskey cotton, surp, dilatons, vikins." The patient indicated that she was not seeing any other physicians for treatment. There was no clarification of this by respondent in the chart. She noted a history of diabetes, asthma, hypertension and arthritis but denied feeling depressed or anxious. She indicated that she smoked one pack of cigarettes per day and denied a history of heavy drinking. A hand written notation of "diabetic neuropathy" was noted at the end of the questionnaire while "RSD lower extremity" was noted on an encounter form, both presumably by respondent. The chart contains a consent form for chronic narcotic pain medication signed by the patient and respondent. Other than above, there is no documentation of a history taken by respondent nor is there any documentation of a physical examination of the patient by respondent. There was a notation of blood pressure (168/105) and pulse (102) on the May 10, 2005, encounter form. There is no documentation that respondent took any steps to address this significant elevation in blood pressure such as repeating the blood pressure measurement at later visits, starting the patient on antihypertensive medication, counseling her about the import of diet and exercise to blood pressure control, counseling her about the impact of uncontrolled hypertension upon her diabetic condition or referring her to another physician for treatment. There was no further development in the chart of substance abuse history. There is no evidence in the record that respondent conducted a diagnostic evaluation by way of laboratory tests or x-rays. There is no discussion in the chart of a differential diagnosis. There is no documentation of a treatment plan or treatment goals. There is no discussion of why an acute onset of pain necessitated high dose opioid therapy before any other evaluation or less risky treatment efforts such as physiotherapy or non-opioid analgesic drugs.

Y. Respondent's chart for patient A.H. contains multiple preprinted encounter forms reflecting dates of service and charges but there is no history or physical examination recorded on these forms nor any progress notes relating to respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment and whether the patient was experiencing any adverse effects from respondent's treatment.

///

Z. Between on or about May 10, 2004, and November 7, 2006, respondent's chart for patient A.H. contains multiple prescriptions by respondent, including 18 for OxyContin 80 mg, number 90, and 18 prescriptions for Dilaudid 4 mg, with quantities ranging from 150 to 240. This represented a high dose opioid therapy. In the chart there is one pharmacy refill request form for Phenergan with codeine cough syrup and Vicodin extra strength (hydrocodone 7.5 mg/acetaminophen 750 mg), quantity 120, signed by respondent on June 9, 2006, with five refills. The records from the Twenty Two Twenty Two Pharmacy contain two prescriptions from respondent for hydrocodone/acetaminophen 7.5/750, one for quantity 100 and the other for 120, on May 10, 2005, and June 9, 2006, respectively, as well as seven prescriptions from respondent for patient A.H. for Phenergan with codeine cough syrup during the same time frame. There is no indication from respondent's medical record for patient A.H. that the patient has a respiratory ailment warranting the use of narcotic cough syrup; there is no work up of the patient's asthma to substantiate prescribing the narcotic cough syrup. The chart contains a patient drug activity report from the Department of Justice indicating that the patient received from another physician five prescriptions for codeine/acetaminophen between January 7, 2005, and August 2, 2005, while under the care of respondent and contrary to the consent the patient signed with respondent. There is no documentation that respondent spoke with the other physician or took any other appropriate action in response to the report. On or about October 10, 2006, respondent prescribed Cymbalta 60 mg, number 30, with four refills, to patient A.H. The patient chart does not contain any documented work up, including a focused examination and history, to support the prescription of Cymbalta. There is no documented investigation of the patient's elevated blood pressure, which can be exacerbated by Cymbalta.

Allegations of Gross Negligence re Patient A.H.

AA. On or about May 10, 2005, and thereafter, respondent was grossly negligent in the care and treatment of patient A.H. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid, Vicodin and Phenergan with codeine

cough syrup.

BB. Between on or about May 10, 2004, and November 7, 2006, respondent was grossly negligent in the care and treatment of patient A.H. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

CC. Between on or about May 10, 2004, and November 7, 2006, respondent was grossly negligent in the care and treatment of patient A.H. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

DD. Between on or about May 10, 2004, and June 9, 2006, respondent was grossly negligent in the care and treatment of patient A.H. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescriptions.

EE. On or about October 10, 2006, and thereafter, respondent was grossly negligent in the care and treatment of patient A.H. when he prescribed Cymbalta to patient A.H. without a prior examination and medical indication for the prescription and without proper follow- up with the patient.

FF. On or about May 10, 2005, and thereafter, respondent was grossly negligent in the care and treatment of patient A.H. when he failed to appropriately address the patient's elevated blood pressure.

Factual Allegations re Patient R.W.

GG. On or about June 28, 2005, patient R.W., a 26-year-old woman, presented to respondent with a complaint of low back pain. According to the patient history questionnaire, the patient had back pain about two hours a day with an intensity of 10/10.

She indicated she had not had any diagnostic testing or treatment for the pain. She denied a history of smoking cigarettes and drinking alcoholic beverages. The patient also complained of a bad chest cold for which she took cough medicine but also denied a history of asthma or lung problems and answered in the negative to questions about any respiratory ailments. There is no documentation that respondent sought to clarify the patient's pulmonary history or that he ever examined her lungs. The chart does not reflect any history taking by respondent nor any physical examination of the patient apart from recording her blood pressure and pulse and a handwritten diagnosis of low back pain on the encounter form for the first visit. There is an informed consent for chronic opioid analgesic therapy signed by the patient and respondent on the initial visit. It does not appear from the chart that the patient was taking opioid medications prior to visiting respondent. On this initial visit, respondent prescribed the patient OxyContin 80 mg three times daily, 90 tablets plus Dilaudid 4 mg, 150 tablets, a potentially fatal dose for a person not currently on opioid medication. According to the chart, respondent did not perform any diagnostic testing. There is no differential diagnosis. There is no documentation of a treatment plan or of treatment goals.

HH. Between on or about June 28, 2005, and November 7, 2006, respondent's chart for patient R.W. contains multiple prescriptions by respondent for OxyContin, Dilaudid, Vicodin (hydrocodone) and Phenergan with codeine cough syrup. This represented a high dose opioid therapy. The medical chart for patient R.W. does not contain any progress notes relating to respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment and whether the patient was experiencing any adverse effects from respondent's treatment. A November 22, 2005, patient activity report from the Department of Justice in the patient's chart reflects that she was not seeing other physicians while under respondent's care between June and September of 2005.

II. On or about August 11, 2005, respondent prescribed patient R.W. Phenergan with codeine, with five refills. On or about September 22, 2005, respondent prescribed patient R.W. Phenergan with codeine, with three refills. On or about October 28, 2005,

respondent prescribed patient R.W. Phenergan with codeine, with five refills. On or about May 15, 2006, respondent prescribed patient R.W. Phenergan with codeine, with four refills. On or about June 19, 2006, respondent prescribed patient R.W. Phenergan with codeine, with three refills.

Allegations of Gross Negligence re Patient R.W.

JJ. On or about June 28, 2005, and thereafter, respondent was grossly negligent in the care and treatment of patient R.W. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of OxyContin and Dilaudid to the patient.

KK. Between on or about June 28, 2005, and November 7, 2006, respondent was grossly negligent in the care and treatment of patient R.W. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

LL. Between on or about June 28, 2005, and November 7, 2006, respondent was grossly negligent in the care and treatment of patient R.W. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

MM. On or about August 11, 2005, September 22, 2005, October 28, 2005, May 15, 2006, and June 19, 2006, respondent was grossly negligent in the care and treatment of patient R.W. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescriptions.

Factual Allegations re Patient E.W.

NN. On or about June 27, 2005, patient E.W., a 39-year-old woman, presented to respondent with complaints, per the patient questionnaire, of pain in her neck, arm, chest,

back, legs and feet that had begun eight years prior to the office visit. She rated her pain intensity as 8/10 and indicated she had not tried any treatments for the pain other than heat and ice. She noted she had not had any diagnostic tests related to her problem and was taking medications she listed as "oskey cotton" and "dilantons." When asked how she spent an average day, she indicated, "I don't know." She listed a history of liver problems or hepatitis. On a symptom check list she reported having breathing problems, repeated chest infections, high blood pressure, chest pain, shortness of breath, leg pain, severe headaches, weakness or numbness in her arms or legs and trouble falling asleep. In a different handwriting at the bottom of one of the questionnaire pages is written, "arthritis pain." The patient noted on the form that she smoked cigarettes but did not drink and had no history of heavy drinking. There is no documentation that respondent sought to clarify inconsistencies in the patient's responses to the questionnaire. There is no appropriate development of the patient's substance abuse history. There is no documentation of a physical examination in the patient's chart. There is no evidence in the chart that respondent conducted a diagnostic evaluation with laboratory testing, x-rays or otherwise. There is no discussion in the chart of a differential diagnosis nor documentation of a treatment plan with treatment goals.

OO. Respondent's chart for patient E.W. contains multiple preprinted encounter forms reflecting dates of service and charges but there is no history or physical examination recorded on these forms nor any progress notes relating to respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment and whether the patient was experiencing any adverse effects from respondent's treatment.

PP. Between on or about June 27, 2005, and October 19, 2006, respondent's chart for patient E.W. contains multiple prescriptions by respondent including 13 prescriptions for OxyContin 80 mg tablets, quantity 90, and 14 prescriptions for Dilaudid 4 mg tablets, quantity 150. The chart contains a pharmacy fax refill request with respondent's signature dated May 16, 2006, authorizing prescriptions of Vicodin extra strength, quantity 120, and promethazine with codeine cough syrup one pint, each with five additional refills.

Allegations of Gross Negligence re Patient E.W.

QQ. On or about June 27, 2005, and thereafter, respondent was grossly negligent in the care and treatment of patient E.W. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of OxyContin and Dilaudid to the patient.

RR. Between on or about June 27, 2005, and October 19, 2006, respondent was grossly negligent in the care and treatment of patient E.W. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

SS. Between on or about June 27, 2005, and October 19, 2006, respondent was grossly negligent in the care and treatment of patient E.W. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

94. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent was engaged in repeated acts of negligence in the care and treatment of patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 93 above are incorporated here as if fully set forth.

B. On or about September 20, 2004, and thereafter, respondent was negligent in the care and treatment of patient P.D. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid and promethazine with codeine cough

syrup.

C. Between on or about September 20, 2004, and October 31, 2006, respondent was negligent in the care and treatment of patient P.D. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

D. Between on or about September 20, 2004, and October 31, 2006, respondent was negligent in the care and treatment of patient P.D. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, (4) periodic reviews of pain management, (5) all prescriptions provided to the patient.

E. On or about May 4, 2004, and thereafter, respondent was negligent in the care and treatment of patient P.E. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid, Vicodin and Phenergan with codeine cough syrup.

F. Between on or about May 4, 2004, and November 17, 2006, respondent was negligent in the care and treatment of patient P.E. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, his adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

G. Between on or about May 4, 2004, and November 17, 2006, respondent was negligent in the care and treatment of patient P.E. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of

pain management.

H. On or about May 4, 2004, and thereafter, respondent was negligent in the care and treatment of patient P.E. when he failed, prior to prescribing him controlled substances, to establish whether the patient was a drug addict by developing a complete substance abuse history, requesting the patient to provide a specimen for random urine drug screening, performing an appropriate history and physical examination, obtaining the patient's prior medical records and speaking with and/or coordinating treatment with prior treating physicians.

I. On or about October 13, 2006, and thereafter, respondent was negligent in the care and treatment of patient P.E. when he prescribed Cymbalta to patient P.E. without a prior examination and medical indication for the prescription and without proper follow- up with the patient.

J. On or about October 28, 2005, November 22, 2005, February 16, 2006, and August 16, 2006, respondent was negligent in the care and treatment of patient P.E. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescription.

K. On or about November 18, 2004, and thereafter, respondent was negligent in the care and treatment of patient W.G. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid, Vicodin and Phenergan with codeine cough syrup.

L. Between on or about November 18, 2004, and June 10, 2006, respondent was negligent in the care and treatment of patient W.G. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, his adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

M. Between on or about November 18, 2004, and June 10, 2006, respondent was negligent in the care and treatment of patient W.G. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

N. Between on or about March 30, 2005, and March 1, 2006, respondent was negligent in the care and treatment of patient W.G. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescriptions.

O. On or about May 10, 2005, and thereafter, respondent was negligent in the care and treatment of patient A.H. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of drugs to the patient, including OxyContin, Dilaudid, Vicodin and Phenergan with codeine cough syrup.

P. Between on or about May 10, 2004, and November 7, 2006, respondent was negligent in the care and treatment of patient A.H. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

Q. Between on or about May 10, 2004, and November 7, 2006, respondent was negligent in the care and treatment of patient A.H. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

R. Between on or about May 10, 2004, and June 9, 2006, respondent was negligent in the care and treatment of patient A.H. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescriptions.

S. On or about October 10, 2006, and thereafter, respondent was negligent in the care and treatment of patient P.E. when he prescribed Cymbalta to patient A.H. without a prior examination and medical indication for the prescription and without proper follow- up with the patient.

T. On or about May 10, 2005, and thereafter, respondent was negligent in the care and treatment of patient A.H. when he failed to appropriately address the patient's elevated blood pressure.

U. On or about June 28, 2005, and thereafter, respondent was negligent in the care and treatment of patient R.W. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of OxyContin and Dilaudid to the patient.

V. Between on or about June 28, 2005, and November 7, 2006, respondent was negligent in the care and treatment of patient R.W. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

W. Between on or about June 28, 2005, and November 7, 2006, respondent was negligent in the care and treatment of patient R.W. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

X. On or about August 11, 2005, September 22, 2005, October 28, 2005, May 15, 2006, and June 19, 2006, respondent was negligent in the care and treatment of patient R.W. when he prescribed Phenergan with codeine cough syrup without a prior examination and medical indication for the prescriptions.

///

Y. On or about June 27, 2005, and thereafter, respondent was negligent in the care and treatment of patient E.W. when he failed to perform an appropriate prior examination and failed to establish a legitimate medical indication for the prescription of OxyContin and Dilaudid to the patient.

Z. Between on or about June 27, 2005, and October 19, 2006, respondent was negligent in the care and treatment of patient E.W. when he failed to provide proper oversight and monitoring of the patient's use of controlled substances, including failing to maintain progress notes reflecting respondent's assessment of the patient's progress toward treatment objectives, her adherence to treatment, whether the patient was experiencing any side effects and whether the treatment regimen with controlled substances should be continued or modified.

AA. Between on or about June 27, 2005, and October 19, 2006, respondent was negligent in the care and treatment of patient E.W. when he failed to maintain adequate and accurate medical records, including failing to appropriately document (1) the patient's pain condition, (2) physical examinations, (3) treatment objectives, and (4) periodic reviews of pain management.

EIGHTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

95. Respondent is subject to disciplinary action under section 725 of the Code in that Respondent clearly excessively, and repeatedly, prescribed medications to patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 93 above are incorporated here as if fully set forth.

NINTH CAUSE FOR DISCIPLINE

(Record Keeping)

96. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records of the medical services he provided to patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 93 above are incorporated here as if fully set forth.

TENTH CAUSE FOR DISCIPLINE

(Violation of Drug Laws)

97. Respondent is subject to disciplinary action under section 2242 of the Code in that Respondent engaged in unprofessional conduct when prescribed, dispensed or furnished dangerous drugs as defined in Business and Professions Code section 4022 without an appropriate prior examination and/or a medical indication. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 93 above are incorporated here as if fully set forth.

ELEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

98. Respondent is subject to disciplinary action under section 2234 of the Code in that Respondent engaged in unprofessional conduct. The circumstances are as follows:

A. The facts and circumstances alleged in paragraphs 20 through 97 above are incorporated here as if fully set forth.

TWELFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

99. Respondent Washington Bryan, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence in the care and treatment of patients. The circumstances are as follows:

Patient S.B. Factual Allegations

A. Respondent's medical record for patient S.B. reflects that on or about August 30, 2004, the patient filled out a "Pain Management Questionnaire" (citing back, knee and left shoulder pain) and a "Consent Form for Chronic Narcotic Pain Management." There is no documentation of any history or physical examination. The patient had Medi-Cal coverage. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status

evaluation, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician.

B. Respondent's medical record for patient S.B. reflects that on or about January 14, 2005, patient S.B. filled out a new "Pain Management Questionnaire" (citing back and neck pain) and a "Consent Form for Chronic Narcotic Pain Management." Although the patient had Medi-Cal coverage and was unemployed, a superbill recorded a payment of $600.00 on this date. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician.

C. Respondent's medical record for patient S.B. contains a superbill dated February 14, 2005, recording the payment of $300.00. There is no documentation of any history or physical examination. The chart contains copies of a prescription for 90 tablets of 80 mg of OxyContin and another for 150 Dilaudid 4 mg for pain. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician.

D. Respondent's medical record for patient S.B. contains a superbill dated April 6, 2005, recording a payment of $300.00 and copies of prescriptions for OxyContin and Dilaudid. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-

morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen.

E. Respondent's medical record for patient S.B. contains a superbill dated May 10, 2005, recording a payment of $300.00 and copies of prescriptions for OxyContin and Dilaudid. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician. A prescription for Phenergan with codeine dated May 14, 2005, is also found in the chart. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen.

F. Respondent's medical record for patient S.B. contains a superbill dated June 8, 2005, recording a payment of $300.00 and copies of prescriptions for OxyContin and Dilaudid. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician. A prescription for Dilaudid dated July 14, 2005, is also found in the chart. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen.

G. Respondent's medical record for patient S.B. contains a superbill dated July 29, 2005, recording a payment of $300.00 and a copy of a prescription for OxyContin. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen.

H. Respondent's medical record for patient S.B. contains a superbill dated September 13, 2005, recording a payment of $300.00 and copies of prescriptions for OxyContin and Dilaudid. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen.

I. Respondent's medical record for patient S.B. contains a superbill dated October 12, 2005, recording a payment of $300.00 and copies of prescriptions for OxyContin and Dilaudid. There is no documentation of any history or physical examination. There is no progress note. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use. There is no documentation of a diagnostic imaging evaluation or of

an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen.

J. Patient S.B. was incarcerated in state prison on October 21, 2005, and was not paroled until February 10, 2008.

K. Respondent's medical record for patient S.B. contains superbills dated November 9, 2005; January 9, 2006, February 3, 2006; March 1, 2006; March 28, 2006; April 25, 2006; May 23, 2006; June 21, 2006; July 19, 2006; August 16, 2006; and September 18, 2006. The superbills record payments of $300.00 for each date. Copies of prescriptions for OxyContin and Dilaudid are also found in the chart for each date. There is no documentation of any history or physical examination for any of the dates. There is no progress note for any of the dates. There is no documentation of inquiry into possible psychiatric co-morbidities, history of illegal drug use or abuse for any of the dates. There is no documentation of a mental status, musculoskeletal or neurological exam to evaluate the degree of disability required for chronic opioid use for any of the dates. There is no documentation of a diagnostic imaging evaluation or of an attempt to obtain prior imaging studies or prior medical records or to contact a prior treating physician for any of the dates. There is no documentation of routine follow-up assessment to evaluate the efficacy of the treatment, to evaluate side effects and to establish a stable regimen for any of the dates. Other prescriptions found in the chart were also signed by Respondent during this time frame: (1) an October 28, 2005, renewal requests for Vicodin ES and Phenergan with codeine with 5 refills; (2) a November 14, 2005, prescriptions for Vicodin ES and OxyContin; (3) a December 7, 2005, prescription for OxyContin and Dilaudid; (4) an April 27, 2006, renewal request for Phenergan with codeine and Vicodin ES; (5) an August 16, 2006, prescription for OxyContin and Dilaudid; (6) a September 12, 2006, prescription for OxyContin and Dilaudid; and (7) an October 31, 2006, prescription for OxyContin and Dilaudid.

////

Patient S.B. Allegations of Gross Negligence

L. From on or about August 30, 2004, through September 18, 2006, Respondent was grossly negligent when he failed to perform and/or document an adequate evaluation of patient S.B., including obtaining objective information by history and physical examination to assess the current degree of disability and the limitations associated with the chronic illness.

M. From on or about August 30, 2004, through September 18, 2006, Respondent was grossly negligent when he failed to obtain and/or document lab or imaging studies to provide objective information of the patient's current condition and degree of disability.

N. From on or about August 30, 2004, through September 18, 2006, Respondent was grossly negligent when he failed to engage in and/or document medical decision-making appropriate to the treatment of patient S.B. as evidenced by the lack of documentation of (1) a diagnosis, (2) any discussion of appropriate treatments including routine therapies such as physical therapy and/or referrals for such treatments, and (3) any discussion of possible adjuvant therapies such as non-steroidal anti-inflammatory drugs (NSAIDs).

O. From on or about August 30, 2004, through September 18, 2006, Respondent was grossly negligent when he failed to perform and/or document routine follow-up to, inter alia, evaluate the efficacy of the treatment and evaluate for possible side effects.

P. From on or about August 30, 2004, through September 18, 2006, Respondent was grossly negligent when he failed to create and/or maintain sufficient documentation to support the long term high dose opioid therapy prescribed to patient S.B. for chronic pain.

Q. From on or about August 30, 2004, through September 18, 2006, given the absence of sufficient documentation to support the long term high dose opioid therapy prescribed to patient S.B. for chronic pain, Respondent was grossly negligent when he engaged in repeated acts of clearly excessive prescribing of narcotic medications to patient S.B.

////

Patient J.E. Factual Allegations

R. Respondent's medical record for patient J.E. reflects that on or about April 19, 2005, the patient was seen "as follow-up evaluation of pain." The chart note stated that pain is gradually worsening and is located in the low pack and is altering normal daily activities with stiffness and decreased ability to physically function. The patient's current medication was listed as Hydrocodone-Acetaminophen 7.5/550 [Vicodin ES] four pills per day. A normal neurological and musculoskeletal examination was charted. No tests were ordered. The progress note stated there was a written agreement for opioid treatment. The chart contained such an agreement dated October 5, 2004, which required the patient to be treated only by Respondent, to see Respondent every month for follow-up and to obtain prescription medications from only one pharmacy. According to the chart, no medications were prescribed. A superbill indicated no charge was made for the visit. There is a lack of documentation of the degree of disability and no focused physical exam to assess that. There is no evidence in the chart of lab or imaging studies to provide objective information of the patient's current condition or degree of stability. There is no diagnosis made. There is no documentation of discussion of appropriate treatment, including the use of routine therapies such as physical therapy or referrals to other specialist. There is no documentation of discussion of adjuvant medication therapies such as using NSAIDs. There is no documentation of the patient's prior medical history and no prior medical records are in the chart. There is no documentation of discussion of the patient's current marijuana use.[4]

S. Respondent's medical record for patient J.E. reflects that on or about August 31, 2005, the patient was seen for initial evaluation of pain. The patient complained that the pain was in the lower back, was worsening and that it altered normal daily activities. A normal examination was charted. No current medications were charted. The clinical

[4] Respondent had previously provided to patient J.E. an October 6, 2004, letter indicating that the patient was under Respondent's care and supervision for treatment of low back pain and recommending the use of marijuana for the treatment of chronic pain and related symptoms.

assessment was that the condition was unchanged from the last visit. No tests were ordered. The plan was "to change to long acting pain medication" and change the short acting medication to Norco. The chart noted the prescription of Halcion .25 mg #60 with no refills for sleeplessness, OxyContin sustained release 12 hour 80 mg #60 as needed for chronic back pain with no refills and Norco 10/325 mg #100 for breakthrough pain with three refills. A superbill indicated that the patient was charged $200.00 of which $100.00 was paid in cash. There is a lack of documentation of the degree of disability and no focused physical exam to assess that. There is no evidence in the chart of lab or imaging studies to provide objective information of the patient's current condition or degree of stability. There is no diagnosis made. There is no documentation of discussion of appropriate treatment, including the use of routine therapies such as physical therapy or referrals to other specialist. There is no documentation of discussion of adjuvant medication therapies such as using NSAIDs. There is no documentation of the patient's prior medical history and no prior medical records are in the chart. There is no documentation of discussion of the patient's current marijuana use.

T. Respondent's medical record for patient J.E. reflects that on or about October 4, 2005, the patient was seen for follow-up evaluation of pain. The patient indicated that improvement in the low back pain was slow. Physical exam was normal. No tests were ordered. The assessment was low back pain with no clinical change from the prior visit. The plan was to increase long acting narcotics to decrease amount of short acting narcotics. The chart noted the prescription of OxyContin sustained release 12 hour 80 mg #90 for chronic back pain. A superbill indicated that the patient was charged $300.00 which was paid in cash. There is a lack of documentation of the degree of disability and no focused physical exam to assess that. There is no evidence in the chart of lab or imaging studies to provide objective information of the patient's current condition or degree of stability. There is no diagnosis made. There is no documentation of discussion of appropriate treatment, including the use of routine therapies such as physical therapy or referrals to other specialist. There is no documentation of discussion of adjuvant medication therapies

such as using NSAIDs. There is no documentation of the patient's prior medical history and no prior medical records are in the chart. There is no documentation of discussion of the patient's current marijuana use.

U. Respondent's medical record for patient J.E. reflects that on or about November 8, 2005, the patient did not show for an appointment. When contacted by phone, the patient said he was feeling much better.

V. On or about December 7, 2005, patient J.E. had a new prescription from Respondent for Norco filled at Savon Drug No. 9588. On December 15 and 26, 2005, January 5, 19 and 30, 2006, the patient obtained refills on this prescription. According to Respondent's medical chart, a further three refills were approved by Respondent on February 6, 2006.

W. Respondent's medical record for patient J.E. reflects that on or about February 3, 2006, the patient was seen for follow-up evaluation of pain. The patient indicated that the low back pain fluctuated but was improving. Existing medications being taken were noted as OxyContin, Norco and Halcion. Physical exam was normal. The assessment was low back pain, condition controlled, improving. The patient was taken off long acting pain medication and prescribed only Norco 10/325 mg #100 (with 2 refills) and Halcion. A superbill indicated that the patient was charged $300.00. There is a lack of documentation of the degree of disability and no focused physical exam to assess that. There is no evidence in the chart of lab or imaging studies to provide objective information of the patient's current condition or degree of stability. There is no diagnosis made. There is no documentation of discussion of appropriate treatment, including the use of routine therapies such as physical therapy or referrals to other specialist. There is no documentation of discussion of adjuvant medication therapies such as using NSAIDs. There is no documentation of the patient's prior medical history and no prior medical records are in the chart. There is no documentation of discussion of the patient's current marijuana use. The Norco prescription (0499106) was filled the same day at Rite Aid Pharmacy 5482. Refills were obtained on this prescription on February 10 and 17, 2006. According to the chart, a

further 3 refills were approved by Respondent on February 28, 2006.

X. On or about February 7, 2006, a new prescription (0636584) from Respondent for Norco was filled at Savon Drug No. 9588. On or about February 16, 2006, another new prescription (0638508) for Norco from Respondent was filled at Savon Drug No. 9588. Refills on this prescription were obtained on February 28 and March 9, 2006. On or about February 28, 2006, a new prescription (0503190) from Respondent for Norco was filled at Rite Aid Pharmacy No. 5482. Refills on this prescription were obtained on March 9 and 30, 2006, April 18, 2006, and May 11, 2006. According to Respondent's chart, four further refills on this prescription were approved by Respondent on June 20, 2006. On or about March 22, 2006, a new Norco prescription (0645539) from Respondent was filled at Savon Drug No. 9588. Refills were obtained on April 6, 2006, May 11 and 30, 2006, and June 14, 2006. On or about June 20, 2006, a new prescription (0520967) from Respondent for Norco was filled at Rite Aid Pharmacy No. 5482. Refills on this prescription were obtained on July 11, 2006, August 9 and 23, 2006, and September 3, 2006. According to Respondent's chart for patient J.E., Respondent denied approval of further refills of this prescription on September 7, 2006. On or about August 1, 2006, a new Norco prescription (0670178) from Respondent was filled at CVS Pharmacy No. 9588. A refill was obtained on August 19, 2006. On or about August 25, 2006, a new Norco prescription (0674653) from Respondent was filled at CVS Pharmacy No. 9588. Refills were obtained on September 19 and 26, 2006, and October 12, 2006. On or about September 12, 2006, a new prescription (0533550) from Respondent for Norco was filled at Rite Aid Pharmacy No. 5482. Refills on this prescription were obtained on September 27, 2006, and October 6, 16 and 26, 2006. On or about November 8, 2006, a new Norco prescription (0810329) from Respondent was filled at CVS Pharmacy No. 9588. Refills were obtained on November 28, 2006, and December 11 and 22, 2006.

Y. Subsequent to the February 3, 2006, office visit, no further office visits were charted for patient J.E. There is no documentation of any follow-up with the patient after that date to determine the patient's continued need for therapy. With the February 7, 2006,

prescription for Norco referenced in paragraph 8.X. above, and the prescriptions that followed, Respondent effectively doubled the amount of pills patient J.E. could obtain each month. Respondent did not chart any rationale for this change in treatment regimen. Respondent did not chart any follow-up visits with the patient to assess his response to the therapy, to indicate whether there was any improvement in the pain level or improvement in function, or to assess whether there were any side effects associated with the opioid regimen.

Patient J.E. Allegations of Gross Negligence

Z. Between on or about April 19, 2005, and December 22, 2006, Respondent was grossly negligent in the following actions and/or omissions, taken separately or together, when he:

(1) Failed, for each office visit, to determine and/or document the degree of disability associated with the symptoms of low back pain by physical examination and/or objective imaging.

(2) Failed, on or about August 31, 2005, to obtain and/or document a clear indication for increasing the effective opioid treatment per day from approximately 30 mg to 160 mg of OxyContin.

(3) Failed, for each office visit, to make and/or document medical decisions appropriate to the therapy, including making and/or documenting a diagnosis to support narcotic therapy, discussing (and/or documenting same) appropriate non-narcotic treatments such as physical therapy or referral to other specialists, and discussing (and/or documenting same) adjuvant therapies such as NSAIDs.

(4) Failed to perform follow-up evaluations with respect to the efficacy of the therapy and the patient's continued need for opioid therapy.

(5) Failed to have and/or document a rationale for increasing the amount of narcotic medication prescribed on and after February 7, 2006.

(6) Failed, for each office visit, to discuss (and/or document same) the side effects, if any, of the ongoing opioid therapy and/or sleep therapy (Halcion).

(7) Failed, for each office visit, to discuss (and/or document same) the patient's concurrent use of marijuana.

AA. Between on or about April 19, 2005, and December 22, 2006, Respondent was grossly negligent when he failed to properly monitor and control the frequency and duration of patient J.E.'s opioid refills.

THIRTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

100. Respondent Washington Bryan, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

Patient S.B. Factual Allegations

A. The facts and circumstances alleged in paragraph 99.A. through 99.K. above are incorporated here as if fully set forth.

Patient S.B. Allegations of Repeated Negligent Acts

B. From on or about August 30, 2004, through September 18, 2006, Respondent was negligent when he failed to perform and/or document an adequate evaluation of patient S.B., including obtaining objective information by history and physical examination to assess the current degree of disability and the limitations associated with the chronic illness.

C. From on or about August 30, 2004, through September 18, 2006, Respondent was negligent when he failed to obtain and/or document lab or imaging studies to provide objective information of the patient's current condition and degree of disability.

D. From on or about August 30, 2004, through September 18, 2006, Respondent was negligent when he failed to engage in and/or document medical decision-making appropriate to the treatment of patient S.B. as evidenced by the lack of documentation of (1) a diagnosis, (2) any discussion of appropriate treatments including routine therapies such as physical therapy and/or referrals for such treatments, and (3) any discussion of possible adjuvant therapies such as non-steroidal anti-inflammatory drugs (NSAIDs).

E. From on or about August 30, 2004, through September 18, 2006, Respondent

was negligent when he failed to perform and/or document routine follow-up to, inter alia, evaluate the efficacy of the treatment and evaluate for possible side effects.

F From on or about August 30, 2004, through September 18, 2006, Respondent was negligent when he failed to create and/or maintain sufficient documentation to support the long term high-dose opioid therapy prescribed to patient S.B. for chronic pain.

G. From on or about August 30, 2004, through September 18, 2006, given the absence of sufficient documentation to support the long term high-dose opioid therapy prescribed to patient S.B. for chronic pain, Respondent was negligent when he engaged in repeated acts of clearly excessive prescribing of narcotic medications to patient S.B.

Patient J.E. Factual Allegations

H. The facts and circumstances alleged in paragraphs 99.R. through 99.Y. above are incorporated here as if fully set forth.

Patient J.E. Allegations of Repeated Negligent Acts

I. Between on or about April 19, 2005, and December 22, 2006, Respondent was negligent in the following actions and/or omissions, taken separately or together, when he:

(1) Failed, for each office visit, to determine and/or document the degree of disability associated with the symptoms of low back pain by physical examination and/or objective imaging.

(2) Failed, on or about August 31, 2005, to obtain and/or document a clear indication for increasing the effective opioid treatment per day from approximately 30 mg to 160 mg of OxyContin.

(3) Failed, for each office visit, to make and/or document medical decisions appropriate to the therapy, including making and/or documenting a diagnosis to support narcotic therapy, discussing (and/or documenting same) appropriate non-narcotic treatments such as physical therapy or referral to other specialists, and discussing (and/or documenting same) adjuvant therapies such as NSAIDs.

(4) Failed to perform follow-up evaluations with respect to the efficacy of the therapy and the patient's continued need for opioid therapy.

(5) Failed to have and/or document a rationale for increasing the amount of narcotic medication prescribed on and after February 7, 2006.

(6) Failed, for each office visit, to discuss (and/or document same) the side effects, if any, of the ongoing opioid therapy and/or sleep therapy (Halcion).

(7) Failed, for each office visit, to discuss (and/or document same) the patient's concurrent use of marijuana.

J. Between on or about April 19, 2005, and December 22, 2006, Respondent was negligent when he failed to properly monitor and control the frequency and duration patient J.E.'s opioid refills.

FOURTEENTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

101. Respondent Washington Bryan, M.D. is subject to disciplinary action under section 725 of the Code in that he repeatedly clearly excessively prescribed narcotic medications to patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraphs 99.A. through 99.K. and 99.R. through 99.Y. above are incorporated here as if fully set forth.

FIFTEENTH CAUSE FOR DISCIPLINE

(Dishonest or Corrupt Acts)

102. Respondent Washington Bryan, M.D. is subject to disciplinary action under section 2234, subdivision (e), of the Code in that he committed acts involving dishonesty and/or corruption which were substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 99.J. through 99.K. above are incorporated here as if fully set forth.

B. Between November 9, 2005, and September 18, 2006, Respondent engaged in acts of dishonesty and/or corruption when he created medical records showing that he provided care and treatment through office visits and prescriptions for controlled substances to patient S.B. when in fact patient S.B. was incarcerated is state prison and did not receive

any care, treatment or prescriptions from Respondent.

SIXTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

103. Respondent Washington Bryan, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and/or accurate records of the medical services provided to patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 99.A. through 99.K. and 99.R. through 99.Y. above are incorporated here as if fully set forth.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

104. Respondent Washington Bryan, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and/or accurate records of the medical services provided to patients S.B. and J. E., not withstanding any assertion that this failure was due to a change in Respondent's electronic medical record keeping.

A. The facts and circumstances alleged in paragraph 99.A. through 99.K. and 99.R. through 99.Y. above are incorporated here as if fully set forth.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

105. Respondent is subject to disciplinary action under section 2234 of the Code in that Respondent engaged in unprofessional conduct. The circumstances are as follows:

A. The facts and circumstances alleged in paragraphs 99 through 104 above are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A61799, issued to Washington Bryan, M.D.

2. Revoking, suspending or denying approval of Washington Bryan, M.D.'s authority to

supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Washington Bryan, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: August 3, 2010

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2008502048
50704264.doc